

# Employment Application Packet

Please complete this Application Packet and send back by either Fax at (Fax Number) or e-mail at (email)

To ensure our compliance with the standards of both our clients and the State, Agency Staffing requires the following documentation in our system.

## REQUIREMENTS:

- RESUME**
  - Explain **GAPS IN EMPLOYMENT**, if any to avoid delays in your Pre-Qualification process
  - Please indicate the **CITY AND STATE** plus **MONTH AND YEAR** per work history
  - Also if you speak any Language other than English.
  
- APPLICATION FOR EMPLOYMENT**
  - Application Form
  - Employment History
  - Emergency Contact
  - Legal Questionnaire
  
- EMPLOYMENT REFERENCE #1**
  
- EMPLOYMENT REFERENCE #2**
  
- CLINICAL SKILLS CHECKLIST – COMPLETED & SIGNED**
  
- PROFESSIONAL CREDENTIALS – Please attach the following when submitting this Application:**
  1. State Professional License – Front and Back copies with signature
  2. Driver's License
  3. BLS/CPR – Front and Back copies with signature. American Heart Association for healthcare provider
  4. ACLS,PALS,MAB,EKG/ARRHYTHMIA Certification as Applicable/Back should be signed, AHA provider
  5. Diploma (Hospital requirement for education verification)
  6. Physician Statement, taken within the last 12 months, \*Physician Statement with Signature of M.D
  7. Chest X-Ray or PPD Test
  8. Drug Screen
  9. Immunization Records (MMR and Varicella)
    - TB/PPD Test
    - Rubella Titre, Rubeola Titre, Mumps Titre
    - Vaccine Zoster Titre, Immunity by History of Disease as Verified by MD and Vaccination
    - Covid-19
  10. Hepatitis B Declination, Proof of Series, or Titre Showing Immunity.

# Application for Employment

(Please complete event if attaching a resume)

---

|  |                   |  |                     |
|--|-------------------|--|---------------------|
| Name (Last, First and Middle Initial)      |                   | Maiden/Other                                 |                     |
| Street Address                             |                   | City   | Select State Zip    |
| E-mail Address                             |                   | Social Security Number                       |                     |
| Date of Birth                              | Driver's License  | Select State                                 | Expiration Date     |
| Home Phone #                               | Alternate Phone # | Cell Phone #                                 | Preferred call time |
| Primary Emergency Contact Name and Phone # |                   | Secondary Emergency Contact Name and Phone # |                     |

---

Date Available: \_\_\_\_\_ Shift Preferred:  Day  Night

Type of position applying for (check all that applies):  Per Diem  8 Weeks  13 Weeks+  Permanent

Do you speak any languages other than English?  Yes  No If yes, Please list \_\_\_\_\_

How were you referred to us?  Advertising  Internet site  Friend / Associate \_\_\_\_\_  
 Other \_\_\_\_\_

Were you recruited by a Staff Member?  Yes  No If yes, Recruiter's name \_\_\_\_\_

Have you done a Travel assignment before?  Yes  No If yes, with which company(s)? \_\_\_\_\_

Are you able to perform the basic functions of the position for which you are applying without any restrictions?  Yes  No  
If no, Please explain \_\_\_\_\_

Position (Job Class) Applying for:

RN  PT  LP/VN  CNA  OT  PTA  Clerical  Other \_\_\_\_\_ Date Available: \_\_\_\_\_

Please use the space below to let us know your preferences in terms of Facility, Commute, Restrictions, Pay, etc.

\_\_\_\_\_

\_\_\_\_\_

---

## Emergency Contact Information

We would like to have the names of two (2) contacts that we could call in the case of emergency. Please provide that information below for our files and reference.

|                        |                          |
|------------------------|--------------------------|
| Primary Contact: _____ | Secondary Contact: _____ |
| Relationship: _____    | Relationship: _____      |
| Address: _____         | Address: _____           |
| _____                  | _____                    |
| Contact No.: _____     | Contact No.: _____       |

# Professional Credentials

Education: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
College or University / Location

Degree Earned: \_\_\_\_\_

Education: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
College or University / Location

Degree Earned: \_\_\_\_\_

Education: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
College or University / Location

Degree Earned: \_\_\_\_\_

## Specialty (Please list most current experience first)

1. \_\_\_\_\_ Years of Experience \_\_\_\_\_ as of (Indicate Date) \_\_\_\_\_

2. \_\_\_\_\_ Years of Experience \_\_\_\_\_ as of (Indicate Date) \_\_\_\_\_

## Professional Licenses (Please attach a copy of each including front and back copies)

1. CA Medical License # \_\_\_\_\_ Expiry Date: \_\_\_\_\_

2. \_\_\_\_\_ Expiry Date: \_\_\_\_\_

3. \_\_\_\_\_ Expiry Date: \_\_\_\_\_

## Certifications (Please attach a copy of each including front and back copies)

BLS / CPR Expiry Date: \_\_\_\_\_  ACLS Expiry Date: \_\_\_\_\_

PALS Expiry Date: \_\_\_\_\_  NRP / NALS Expiry Date: \_\_\_\_\_

MAB Expiry Date: \_\_\_\_\_  CCRN Expiry Date: \_\_\_\_\_

CNOR Expiry Date: \_\_\_\_\_  TNCC Expiry Date: \_\_\_\_\_

EKG Cert Expiry Date: \_\_\_\_\_  CHEMO Expiry Date: \_\_\_\_\_

Other: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

## Employment History (Please list in order, most recent first and explain gaps in employment if any)

Date Employed: From: \_\_\_\_\_ To: \_\_\_\_\_

Facility: \_\_\_\_\_

Position Held: \_\_\_\_\_

FT  PT  Traveler-Agency \_\_\_\_\_

Address: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

Business Phone: \_\_\_\_\_

May We Contact?  Yes  No

Specialty Unit: \_\_\_\_\_

City and State: \_\_\_\_\_

Pay / HR: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

# Employment History <sup>cont.</sup> (Please list in order, most recent first and explain gaps in employment if any)

Date Employed: From: \_\_\_\_\_ To: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Position Held: \_\_\_\_\_  
 FT  PT  Traveler-Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_

---

Business Phone: \_\_\_\_\_  
May We Contact?  Yes  No  
Specialty Unit: \_\_\_\_\_  
City and State: \_\_\_\_\_  
Pay / HR: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

---

Date Employed: From: \_\_\_\_\_ To: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Position Held: \_\_\_\_\_  
 FT  PT  Traveler-Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_

---

Business Phone: \_\_\_\_\_  
May We Contact?  Yes  No  
Specialty Unit: \_\_\_\_\_  
City and State: \_\_\_\_\_  
Pay / HR: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

---

Date Employed: From: \_\_\_\_\_ To: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Position Held: \_\_\_\_\_  
 FT  PT  Traveler-Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_

---

Business Phone: \_\_\_\_\_  
May We Contact?  Yes  No  
Specialty Unit: \_\_\_\_\_  
City and State: \_\_\_\_\_  
Pay / HR: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

---

Date Employed: From: \_\_\_\_\_ To: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Position Held: \_\_\_\_\_  
 FT  PT  Traveler-Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_

---

Business Phone: \_\_\_\_\_  
May We Contact?  Yes  No  
Specialty Unit: \_\_\_\_\_  
City and State: \_\_\_\_\_  
Pay / HR: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

---

Date Employed: From: \_\_\_\_\_ To: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Position Held: \_\_\_\_\_  
 FT  PT  Traveler-Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Immediate Supervisor: \_\_\_\_\_

---

Business Phone: \_\_\_\_\_  
May We Contact?  Yes  No  
Specialty Unit: \_\_\_\_\_  
City and State: \_\_\_\_\_  
Pay / HR: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Position applied for: \_\_\_\_\_

## LEGAL QUESTIONNAIRE

### Have you ever:

1. been named as a defendant in a malpractice action? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Who was your employer at that time? \_\_\_\_\_

2. had a license or certification in any jurisdiction limited, suspended, revoked or voluntarily relinquished? \_\_\_\_\_

If yes, when? \_\_\_\_\_ In what state? \_\_\_\_\_

3. been licensed or practiced professionally under a different name? \_\_\_\_\_

If yes, under what name? \_\_\_\_\_ and what state? \_\_\_\_\_

4. Are you eligible to work in the U.S.?  Yes  No Alien ID number \_\_\_\_\_ (if applicable)

5. been denied a license? \_\_\_\_\_ If yes, what state? \_\_\_\_\_ when? \_\_\_\_\_

What reason? \_\_\_\_\_

6. been convicted by misdemeanor, felony including traffic violations? \_\_\_\_\_

If yes, when? \_\_\_\_\_ in what state? \_\_\_\_\_

What county? \_\_\_\_\_

(this includes any offense where you were found guilty, plead guilty or plead nolo contendere (no contest). You may omit: a conviction of misdemeanor while under the age of 18, if the records were sealed. Any conviction specified in Health and Safety code which pertains to various marijuana offenses (a conviction will not necessarily disqualify you from consideration for employment).

7. been arrested and are you out on bail on your own recognizance and still awaiting trial? \_\_\_\_\_

8. been released or discharged from employment or resigned to avoid such release or discharged? \_\_\_\_\_

If yes, please provide dates and circumstances? \_\_\_\_\_

9. had your driver's license suspended or revoked? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Please explain why? \_\_\_\_\_

My signature certifies that all information contained within my application is correct and maybe verified by Agency Staffing in compliance with State Law. It also acknowledges that I am aware that it is my responsibility to review and policy and procedure documents of each hospital/facility in which I work, prior to beginning my initial shift.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_ Position \_\_\_\_\_

I have reviewed the applicant's qualifications and skills that qualify for the position.

Evaluator's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Employment Reference Check #1

- Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the references such as Charge RN, RN Supervisor, DON, Nurse Manager. The reference MUST be someone who the candidate reported to directly on the floor unit. •

\_\_\_\_\_  
**Applicant's Name** \_\_\_\_\_  
**Position Held**

\_\_\_\_\_  
**Dates of Employment** **Current / Former Employer**  
(From month & year – To month & year)

\_\_\_\_\_  
**City** **State** **Supervisor's Name**

I hereby give permission to the above named employer to release information to Agency regarding my performance while employed at the facility.

\_\_\_\_\_  
**Applicant's Signature** **Date**

## Employment History

The person above is applying for an employment with Agency Staffing and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

Is this employee eligible for rehire?  **YES**  **NO**

| Personal Evaluation              | Above Average            | Satisfactory             | Did not meet expectations | Poor                     |
|----------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| Clinical Competency              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Quality of Work                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Quantity of Work                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Attitude and Cooperation         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Ability to get along with others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Adaptability to Work Situations  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Dependability                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Attendance and Punctuality       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Personal Appearance              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

**Comments:**

# Employment Reference Check #2

- Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the references such as Charge RN, RN Supervisor, DON, and Nurse Manager. The reference MUST be someone who the candidate reported to directly on the floor unit. •

\_\_\_\_\_  
**Applicant's Name** \_\_\_\_\_  
**Position Held**

\_\_\_\_\_  
**Dates of Employment** **Current / Former Employer**  
(From month & year – To month & year)

\_\_\_\_\_  
**City** **State** \_\_\_\_\_  
**Supervisor's Name**

I hereby give permission to the above named employer to release information to Agency regarding my performance while employed at the facility.

\_\_\_\_\_  
**Applicant's Signature** \_\_\_\_\_  
**Date**

## Employment History

The person above is applying for an employment with Agency Staffing and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

Is this employee eligible for rehire?  **YES**  **NO**

| Personal Evaluation              | Above Average            | Satisfactory             | Did not meet expectations | Poor                     |
|----------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|
| Clinical Competency              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Quality of Work                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Quantity of Work                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Attitude and Cooperation         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Ability to get along with others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Adaptability to Work Situations  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Dependability                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Attendance and Punctuality       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |
| Personal Appearance              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> |

**Comments:**

\_\_\_\_\_  
**Employer's Signature** \_\_\_\_\_  
**Title** \_\_\_\_\_  
**Date**

**Note to Staffer – Please indicate this is verbal Verification:** \_\_\_\_\_

# **Employee Handbook Acknowledgement Form**

I acknowledge that I have received a copy of Agency Employee Handbook. I acknowledge that I have been informed that the complete Agency employee handbook.

I understand that in processing my application with Agency an investigation may be made in which information is obtained through personal interviews, and a review of information held by law enforcement or other government agencies. I authorize you to verify my past employment and education, criminal records, motor vehicle records, personal references, and other job related data provided on this application, or via the interview process. I authorize appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquires or disclosures. A consumer report may be generated summarizing this information. I further understand and waive my right of privacy in this investigation and release and hold harmless Agency from any liability. I agree that any decision to hire me is contingent upon the results of my report and certify that all statements and answers on my application, resume, or Interview are true and complete to the best of my knowledge. I understand that if any statements are false or that if information has been omitted, this will be cause for disqualification and immediate termination of my employment if employed. I further authorize Agency to check my credit and conviction records, as needed, on a continuous basis as it relates to my employment. I am granting Agency authorization to release confidential medical Information upon the request from Agency clients while I am actively working at the client's facility and /or during the profiling and placement processes.

I understand that Agency's goal is to always provide me with a consistent level of service. If for any reason I am dissatisfied with Agency' service or the service provided by one of Agency Clients, I am encouraged to contact the local manager to discuss the issue. Agency has processes in place to resolve customer complaints in an effective and efficient manner. If the resolution does not meet my expectation, I am encouraged to call the Agency corporate office. A corporate representative will work with me to resolve my concern. I understand that any individual or organization that has a concerns about the quality and safety of patient care delivered by Agency healthcare professionals, which has not been addressed by Agency management, is encouraged to contact the State Regulatory. Agency demonstrates this commitment by taking no retaliatory or disciplinary action against employees when they do report safety or quality of care.

I have read and understand the entire Agency policies and my requirements.

I understand that if I have any questions and/or need clarification for items addressed in the handbook, it is my responsibility to contact the Agency office to discuss.

---

**EMPLOYEE NAME**

---

**EMPLOYEE SIGNATURE**

---

**DATE**

# CONFIDENTIALITY AGREEMENT

It is the responsibility of all Healthcare workforce members, including employees, medical staff, and office staff to preserve and protect confidential patient, employee and business information.

The Federal Health Insurance Portability Accountability Act (the "Privacy Rule"), govern the release of patient identifiable information by home health agencies and other health care providers. These laws establish protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

***Confidential Patient Care Information includes:*** Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. (Note: this information is defined in the Privacy Rule as "protected health information.") Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Computer and department based computerized patient data; and
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient

***Confidential Employee and Business Information includes, but is not limited to, the following:***

- Employee home telephone number and address;
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from the Agency records which if disclosed, would constitute unwarranted invasion of privacy; or
- Disclosure of Confidential business information that would cause harm to AGENCY.

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.
2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to AGENCY and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.
3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of AGENCY,

or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of AGENCY affairs.

4. AGENCY Administration performs audits and reviews patient records in order to identify inappropriate access.
  
5. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. I will only access the minimum necessary information to satisfy my job role or the need of the request.
  
6. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.
  
7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.
  
8. My obligation to safeguard patient confidentiality continues after my termination of employment with the AGENCY.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that the AGENCY may, as applicable and as it deems appropriate, pursue disciplinary action up to and including my termination from the AGENCY.

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Department/Role: \_\_\_\_\_

**Acknowledgement of Annual Education and Confidentiality of Patient Healthcare Information**

- |   |  |
|---|--|
| Administrative                                    | • End Of Life Care                     |
| Code Of Conduct                                   | • Emergency Codes                      |
| Standards of Conduct                              | • Age specific                         |
| Dress Code / Fingernail Policy                    | • Education EMTALA                     |
| Substance Abuse : Drugs in the Workplace          | • The HIPPA Privacy                    |
| Sexual and Other Unlawful Harassment              | • Rule Body Mechanics                  |
| Customer service                                  | • Advance Directives                   |
| Physical Assault / Workplace Violence             | • Understanding Cultural Diversity     |
| Child & Elder Abuse                               | • Discharge Planning                   |
| Safety Management                                 | • Patient Rights and                   |
| Life Safety (FIRE) Management                     | • Responsibilities                     |
| Environmental Safety                              | • Utility Management                   |
| Emergency Preparedness / Disaster Safety          | • Patient Education                    |
| Electrical Safety                                 | • Medical Equipment                    |
| Chemical Safety / Hazardous Communications        | • Management Pain Management           |
| Joint Commission Education                        | • Radiation                            |
| National Patient Safety Goals                     | • Safety Fall                          |
| Do-Not-Use Abbreviations                          | • Prevention                           |
| Infection Control                                 | Preventing Medication Errors           |
| CDC Hand Hygiene Guidelines                       | Compliant Resolution (Staff and        |
| Isolation and Standard Precautions                | Customer) Human Resources              |
| Bloodborne Pathogens                              | Performance Improvement and Education  |
| Tuberculosis                                      | Program Reporting Any Issues           |
| Medication Safety and Documentation System (MSDS) | Clinical Incidents and Sentinel Events |
| Suspected Abuse : Identification, Treatment and   |  |
| Reporting Domestic Violence                       |  |
| Nursing Essentials                                |  |
| Restraints  |  |

I understand that the above mentioned materials provide guidelines and summary information about the company's policies and procedures. I also understand that it is my responsibility to read, understand, become familiar with, and comply with the standards that have been established.

Name : \_\_\_\_\_

Signature : \_\_\_\_\_

Date : \_\_\_\_\_

## **Authorization to Disclose information on Employment file, Background check, Medical Records and Drug Screening**

---

By affixing my signature hereunder, I authorize Agency to release any and all confidential employment background check and medical information contained in my employment file to any medical facility or entity with which Agency has staffing agreement, and to any other governmental or regulatory agency such agency's request. For all other purposes, Agency Staffing, Inc, shall keep my employment confidential and shall advise any medical facility or other entity to which records have been provided to also keep such record confidential. I hereby hold Agency harmless for any result (s) that arises with regards to the release of this confidential information by Agency. Medical records information is confidential and Agency will instruct client facilities and / or other entities to treat the provided information confidential as well.

I consent to a urine, blood or breath sample for the purpose of an alcohol drug, intoxicant or substance abuse screening test. Furthermore, I consent to the release of the results for purposes for determining the fitness of employment or continued employment.

I authorize Agency to contact past employers and references regarding my employment history. I hereby release all previous employers and references from any liability for furnishing this information in this application, reference information and medical information to Agency and any facilities I might be sent on assignment.

My signature hereunder further indicated that I have read and understood the Employee authorization to release confidential information on employment file, background check, medical records and drug screening.

I certify that the facts contained in this application are true and accurate. I authorize the employer to investigate any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

*Agency does not discriminate in respect to hiring, termination, compensations and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed or disability.*

---

**Name (Print Name)**

---

**Signature**

---

**Date**

# PHYSICIAN'S STATEMENT

---

I hereby authorize Agency Staffing to use or disclose this information to its client facilities, which may be relevant in evaluating my qualifications for employment opportunities and related activities.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

---

I certify that \_\_\_\_\_ is in good physical and mental health, free of any communicable diseases, and is able to physically perform the job functions without restrictions.

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient's Social Security Number

---

Physician's Signature

---

Date of Medical Examination

---

Physician's License Number

---

Physician's Name

**CLINIC STAMP:**  
(Please make sure to have  
this stamped by the clinic)



# **TB QUESTIONNAIRE**

**Employment Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**STEP I:**

If you have had a positive PPD in the past, **go to STEP II.** If you received PPD's on an annual basis, complete **STEP I ONLY.**

**DATE OF LAST PPD:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**RESULTS OF LAST PPD IN MM:** \_\_\_\_\_

**STEP II:**

Since you have had a positive / sensitive PPD and are no longer required to have an annual chest x-ray, the following is to be completed annually and maintained in the personnel file. However, you must have the results of at least one XRAY on file.

**DATE OF LAST XRAY:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Please read and put a checkmark in the correct YES / NO space if you are experiencing any of the following symptoms or if any of the following apply to you:

|  | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|
| 1. Unplanned loss of weight (>10% of body weight).....   | _____      | _____     |
| 2. Night sweats.....   | _____      | _____     |
| 3. Fever lasting several weeks.....  | _____      | _____     |
| 4. Frequent coughing in the absence of a cold or flu .....   | _____      | _____     |
| 5. Coughing blood-streaked sputum.....   | _____      | _____     |
| 6. Unusual tiredness or weakness lasting weeks.....  | _____      | _____     |
| 7. Pain in chest when taking a breath .....  | _____      | _____     |
| 8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease<br>or liver disease?..... | _____      | _____     |
| 9. Have you been recently been exposed<br>to a family member or other with active TB?.....                         | _____      | _____     |

If you checked YES to any of the above questions, are you currently treating with a physician?

\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**

Please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IF YOU DEVELOP ANY OF THE SYMPTOMS LISTED ABOVE, PLEASE CONTACT YOUR PHYSICIAN AND AGENCY **IMMEDIATELY.** A CHEST X-RAY **MUST** BE PERFORMED PRIOR TO WORKING AGAIN.

SIGNATURE: \_\_\_\_\_

## Hepatitis B Vaccine informed consent / waiver

### **HEPATITIS B**

Is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with hepatitis B recover completely but approximately 5-10% becomes chronic carriers of the virus. Most of these people have no symptoms but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. **HBV also appears to be a causative factor in the development of live cancer.** Thus, immunization against hepatitis can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

### **VACCINE**

The Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of highly purified formalin-inactivated hepatitis B antigen (viral coating material). It has been extensively tested for safety in chimpanzees and three doses of vaccine achieve high levels of surface antibody. (anti-HBS) and protection against Hepatitis B. Persons with immune system abnormalities such as dialysis patients have less response to the vaccines but, over half of those receiving it do develop antibodies. Full immunization requires 3 doses of vaccine over 6 month's period although; some persons may not develop immunity after 3 doses. There is no evidence that the vaccine has ever caused hepatitis B or AIDS. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time, but is probably long term.

### **POSSIBLE SIDE EFFECTS**

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experienced tenderness and redness at the site injection. Low grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibilities exist that more serious side effects may be identified in the future.

---

### **Declination**

*I understand that due to my occupational exposure to blood and other potentially infectious materials. I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed and have the opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccine. I understand that I must have three (3) doses of vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effects from the vaccine. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B which is a serious disease.*

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

---

### **Attestation**

*I have already been vaccinated for Hepatitis B. I will be able to provide the proper documentation or record of my vaccination.*

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

# Respiratory Fit Test

Participant's Name (Please print): \_\_\_\_\_

Classification: \_\_\_\_\_ Sensitivity # (Number of squeezes needed to detect taste): \_

|                                       |                 |                 |
|---------------------------------------|-----------------|-----------------|
| <b>Breathing normally</b>             | <b>___ Pass</b> | <b>___ Fail</b> |
| <b>Breathing deeply</b>               | <b>___ Pass</b> | <b>___ Fail</b> |
| <b>Turning head from side to side</b> | <b>___ Pass</b> | <b>___ Fail</b> |
| <b>Nodding head up and down</b>       | <b>___ Pass</b> | <b>___ Fail</b> |
| <b>Resuming normal breathing</b>      | <b>___ Pass</b> | <b>___ Fail</b> |
| <b>Bending Over</b>                   | <b>___ Pass</b> | <b>___ Fail</b> |
| <b>Grimace (15 seconds)</b>           | <b>___ Pass</b> | <b>___ Fail</b> |
| <b>Speaking</b>                       | <b>___ Pass</b> | <b>___ Fail</b> |

Based on standard criteria used in respiratory fit-testing procedures, the above participant has the following designation after being tested:

**\_\_\_ Alpha Protech N95**      **\_\_\_ 3M N95**

The above participant has been determined to be fitted for the following size respirator:

**\_\_\_ SMALL**                      **\_\_\_ MEDIUM**                      **\_\_\_ LARGE**

Tested By (Print Name): \_\_\_\_\_

Tester's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Safe use of respiratory equipment is the responsibility of the user. Re-testing shall be performed in the event of a weight change of 20 pounds or more, significant facial scarring, major dental changes, cosmetic surgery or any other change which may affect respirator sealing. It is the responsibility of the wearer to inform their supervisor of the OSHA-regulated facility of any changes necessary for re-testing.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Vaccination Attestation Form

## COVID-19 VACCINE

- I have been vaccinated for Covid-19. Date \_\_\_\_\_ (On file agency)
- I have a contraindication to receiving the Covid-19 vaccine.
- I decline the Covid-19 vaccine, and I understand that because I work in a healthcare environment I may place patients or co-workers at risk of illness or death if I work while infected with Covid-19 virus. I am required to wear a mask at all times while in any clinical area. My agency and manager, including division and department leadership will be notified that I declined.

## ANNUAL FLU VACCINE

- I have been vaccinated for influenza this flu season. Date \_\_\_\_\_ (On file with agency)
- I have a contraindication to receiving the influenza vaccine.
- I decline the influenza vaccine, and I understand that due to my occupational exposure, I may be at risk of acquiring influenza infection. In addition, I may spread influenza to my patients and other healthcare workers, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for influenza complications. Accordingly, I understand that for infection control purposes I will be required to wear a surgical mask (except in the main lobby or cafeteria) throughout the flu season.

## H1N1 VACCINE

- I have been vaccinated for H1N1 flu season. Date \_\_\_\_\_ (On file agency)
- I have a contraindication to receiving the H1N1 flu vaccine.
- I decline the H1N1 vaccine, and I understand that because I work in a healthcare environment I may place patients or co-workers at risk of illness or death if I work while infected with H1N1 (flu) virus. I am required to wear a mask at all times while in any clinical area during the influenza season. My agency and manager, including division and department leadership will be notified that I declined.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Attestation

\_\_\_\_\_  
Agency Representative Signature

## TDAP Immunization Declination Form

I understand that my occupational exposure to patients, blood or other potentially infectious materials at healthcare facilities with the following vaccine preventable diseases puts me at risk of acquiring the disease. I have had the opportunity to be vaccinated, however, I choose to decline the vaccination(s) checked below at this time. I understand that by declining vaccine protection I continue to be at risk of acquiring the disease.

\_\_\_\_\_ I have received the TDAP vaccine on \_\_\_\_\_(date)

\_\_\_\_\_ I have received TD vaccine on \_\_\_\_\_(date)

\_\_\_\_\_ I refuse vaccination at this time

I understand that in the event of exposure, I may be requested to not visit healthcare facilities for at least the incubation period of the disease to which I have been exposed.

I acknowledge that each healthcare facility determines vaccination requirements, and that a vaccination declination may not satisfy these requirements.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Welcome to our Agency. Your employment at Agency is at will and either party may terminate employment with or without cause. This agreement is not designed to be a contract or to alter the at-will nature of the employment relationship. If you accept employment with Agency, you agree to abide by the Company's rules and policies set forth in this agreement and in the employee manual.**

1. I understand that I will be required to provide, in a timely manner, all necessary documentation, including but not limited to, my resume, licenses, certificates, physical report, drug screens, background checks etc. in order for me to be approved for any travel/per-diem assignment with a Agency client. Failure to do so may result in termination of my employment with Agency.
2. I understand that as part of the above approval process, an investigation may be made in which information is obtained through personal interviews, and a review of information held by law enforcement or other government agencies. I hereby authorize you to verify my past employment and education, criminal records, motor vehicle records, personal references, and other job related data provided on this application, or via the interview process. I authorize appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquiries or disclosure.
3. I understand that I am not in any obligation to accept an assignment offered by Agency. But once I accept a travel/per-diem assignment, I pledge the following:
  - a. To cooperate with the Client's reasonable instructions and accept the direction, supervision, and control of any and all responsible person(s) in the Client facility
  - b. To observe any relevant rules and regulations of the Client facility to which my attention has either been drawn or which I might reasonably be expected to ascertain
  - c. To not engage in any conduct detrimental to the interests of the Client
  - d. To honor my commitment to complete any assignment/shift that I have accepted. If I fail to complete any assignment/shift, I understand that I have voluntarily terminated my employment with Agency.
4. I understand that I am to contact my Agency representative immediately if I am experiencing any difficulty on my assignment/shift or if there are any changes in job description, location, or working hours by the Client.
5. I am to contact Agency immediately if it is impossible for me to report to work. Agency staffers are available 24/7, so you may call us any time of the day or night. Please call us in enough time that we might schedule a replacement for your position. **I understand that if I do not report to my assignment and/or do not call Agency, I have voluntarily terminated my employment with Agency.** I understand that I must notify Agency beforehand if I am late for work or take time off, **failing which I understand that I have voluntarily terminated my employment with Agency.**
6. If I am confirmed for a shift and I cancel my availability for that shift later than 2 hours before the start of that shift, then I may be required to pay a late cancellation fee equivalent to 4 hours times the Client bill rate. The late cancellation penalty will be applied to my payroll by deducting the full amount from the next payroll cycle.
7. While on a temporary assignment, if the Client offers me a permanent position or if one is discussed, I will contact my Agency representative immediately. All fees and conditions are to be handled by Agency. It is unlikely that one of Agency's Clients would ask me to work for them on my own rather than through Agency. I understand that if I go work directly for a Client within one year of my temporary assignment, I will be responsible for paying all employment fees or charges incurred.
8. I understand that Agency is committed to maintaining a safe working environment for all employees. If I am ever asked to do anything unsafe, observe unsafe working conditions, or am injured at work, I will contact Agency immediately. Furthermore, I agree to perform all work in as safe a manner as possible. If I experience an accident or injury while working for Agency, I will notify Agency within 48 hours of the incident.

9. I understand that all client and patient information supplied to me shall be held in strictest confidence, and all product and materials, including, but not limited to, patent records, client records, documentation, reports, charts, manuals, letters, programs and any and all other sources of information given to me or obtained by me from the client or at the work location will be returned to the Client at the completion of my shift/assignment. I also agree not to disclose any company trade secrets or confidential information of Agency or its Client to any other entities or individuals.
10. Agency issues paychecks every Week for the hours worked in the preceding week. I understand I am required to present to Agency, EVERY MONDAY, an actual timesheet signed by the Client in order to have my paycheck issued on Friday. If I fail to provide such time card in a prompt manner, I understand that it will result in my pay being carried over to the next pay period.
11. I understand that ALL overtime hours must be pre-authorized by Agency. If I work overtime that is not pre-authorized, I accept and understand that I will not be paid for those hours. I further understand that all matters relating to the Agency wages and rates are confidential and I will not discuss them with Clients, other employees of client or Agency, or any co-worker at the work location, and in doing so, could result in my immediate dismissal from the assignment and possible termination from Agency.
12. I understand that any monies due Agency resulting from loans, advances, damaged property, lost property including badges, or unauthorized use of property, including, but not limited to late shift cancellation penalties, the unauthorized or improper use of telephone, postage meters, computer equipment, software etc. at Agency or the Client, may be deducted from my paycheck(s).
13. **When assigned to a contract or per-diem assignment, I understand that within 24 hours from the last day of my assignment, I am required to confirm my availability for a new assignment. I understand that it must be in WRITING ONLY, by either email to OR fax. I accept and understand that when I do not email or fax my availability within the specified time period, I am refusing further work with Agency and thereby voluntarily resigning from my employment with Agency. I understand that my unemployment benefits may be denied when I voluntarily resign my employment with any company.**
14. I understand that the assignment is based on the agreement between Agency Staffing and the Client Facility. Client Facility has the right and privilege to cancel or modify the terms of the assignment with or without notice. I understand and accept that Agency will not be liable for any consequential damages, losses, expenses, inconveniences, or loss of alternative employment as a result of Client Facility's changes to the assignment. I understand Agency Staffing will be obligated to pay only for the approved hours worked as indicated on a client-approved timesheet.
15. I understand and agree that in case of dispute or controversy arising from or relating to this Employment Agreement, the matter shall be referred for resolution to Agency, whose decision shall be final and binding on both parties.

**As a condition of my employment with Agency, I hereby acknowledge and agree to the above on this day of \_\_\_\_\_ . I acknowledge that before I signed the document, I was provided a copy for my review and was advised to seek legal counsel before signing this document.**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**WITNESSED BY**

\_\_\_\_\_  
**DATE**



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No.1615-0047  
Expires 07/31/2026

**START HERE:** Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

**ANTI-DISCRIMINATION NOTICE:** All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

**Section 1. Employee Information and Attestation:** Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

|  |                             |   |                            |                           |                                |   |
|--|-----------------------------|---|----------------------------|---------------------------|--------------------------------|---|
| Last Name (Family Name)  |                             | First Name (Given Name)   |                            | Middle Initial (if any)   | Other Last Names Used (if any) |   |
| Address (Street Number and Name)   |                             |   | Apt. Number (if any)       | City or Town              |                                | State<br>ZIP Code                               |
| Date of Birth (mm/dd/yyyy)   | U.S. Social Security Number |   | Employee's Email Address   |                           |                                | Employee's Telephone Number                     |
| <p><b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b></p> |                             | Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.): |                            |                           |                                |   |
|  |                             | <input type="checkbox"/> 1. A citizen of the United States  |                            |                           |                                |   |
|  |                             | <input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)                                    |                            |                           |                                |   |
|  |                             | <input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)  |                            |                           |                                |   |
| <input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)  |                             |   |                            |                           |                                |   |
| If you check <b>Item Number 4.</b> , enter one of these:   |                             |   |                            |                           |                                |   |
| USCIS A-Number   |                             | OR  | Form I-94 Admission Number |                           | OR                             | Foreign Passport Number and Country of Issuance |
| Signature of Employee  |                             |   |                            | Today's Date (mm/dd/yyyy) |                                |   |

**If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the [Preparer and/or Translator Certification](#) on Page 3.**

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

|                           | List A   | OR | List B | AND | List C |
|---------------------------|--|----|--------|-----|--------|
| Document Title 1          |  |    |        |     |        |
| Issuing Authority         |  |    |        |     |        |
| Document Number (if any)  |  |    |        |     |        |
| Expiration Date (if any)  |  |    |        |     |        |
| Document Title 2 (if any) | <p><b>Additional Information</b></p><br><br><br><br><p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p> |    |        |     |        |
| Issuing Authority         |  |    |        |     |        |
| Document Number (if any)  |  |    |        |     |        |
| Expiration Date (if any)  |  |    |        |     |        |
| Document Title 3 (if any) |  |    |        |     |        |
| Issuing Authority         |  |    |        |     |        |
| Document Number (if any)  |  |    |        |     |        |
| Expiration Date (if any)  |  |    |        |     |        |

|  |  |  |
|--|--|--|
| <p><b>Certification:</b> I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.</p> |  | First Day of Employment (mm/dd/yyyy):                                      |
| Last Name, First Name and Title of Employer or Authorized Representative   |  | Signature of Employer or Authorized Representative                         |
|  |  | Today's Date (mm/dd/yyyy)  |
| Employer's Business or Organization Name   |  | Employer's Business or Organization Address, City or Town, State, ZIP Code |

**For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.**

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

\* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

**Examples of many of these documents appear in the Handbook for Employers (M-274).**

| LIST A<br>Documents that Establish Both Identity and Employment Authorization   | OR | LIST B<br>Documents that Establish Identity   | AND | LIST C<br>Documents that Establish Employment Authorization   |
|---|----|---|-----|---|
| <ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</li> </ol> </li> </ol> </li> <li>6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI</li> </ol> | OR | <ol style="list-style-type: none"> <li>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</li> <li>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol> | AND | <ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security               <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol> |
| <p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>  |    |   |     |   |
| <ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>  | OR | <p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>   | AND | <p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>   |

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



# Supplement A, Preparer and/or Translator Certification for Section 1

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS  
Form I-9  
Supplement A  
OMB No. 1615-0047  
Expires 07/31/2026

|  |  |   |
|--|--|---|
| Last Name ( <i>Family Name</i> ) from <b>Section 1</b> . | First Name ( <i>Given Name</i> ) from <b>Section 1</b> . | Middle initial (if any) from <b>Section 1</b> . |
|--|--|---|

**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

|   |                                  |                                  |          |
|---|----------------------------------|----------------------------------|----------|
| Signature of Preparer or Translator       |                                  | Date ( <i>mm/dd/yyyy</i> )       |          |
| Last Name ( <i>Family Name</i> )          | First Name ( <i>Given Name</i> ) | Middle Initial ( <i>if any</i> ) |          |
| Address ( <i>Street Number and Name</i> ) | City or Town                     | State                            | ZIP Code |

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

|   |                                  |                                  |          |
|---|----------------------------------|----------------------------------|----------|
| Signature of Preparer or Translator       |                                  | Date ( <i>mm/dd/yyyy</i> )       |          |
| Last Name ( <i>Family Name</i> )          | First Name ( <i>Given Name</i> ) | Middle Initial ( <i>if any</i> ) |          |
| Address ( <i>Street Number and Name</i> ) | City or Town                     | State                            | ZIP Code |

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

|   |                                  |                                  |          |
|---|----------------------------------|----------------------------------|----------|
| Signature of Preparer or Translator       |                                  | Date ( <i>mm/dd/yyyy</i> )       |          |
| Last Name ( <i>Family Name</i> )          | First Name ( <i>Given Name</i> ) | Middle Initial ( <i>if any</i> ) |          |
| Address ( <i>Street Number and Name</i> ) | City or Town                     | State                            | ZIP Code |

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

|   |                                  |                                  |          |
|---|----------------------------------|----------------------------------|----------|
| Signature of Preparer or Translator       |                                  | Date ( <i>mm/dd/yyyy</i> )       |          |
| Last Name ( <i>Family Name</i> )          | First Name ( <i>Given Name</i> ) | Middle Initial ( <i>if any</i> ) |          |
| Address ( <i>Street Number and Name</i> ) | City or Town                     | State                            | ZIP Code |



# Supplement B, Reverification and Rehire (formerly Section 3)

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS  
Form I-9  
Supplement B  
OMB No. 1615-0047  
Expires 07/31/2026

|  |  |   |
|--|--|---|
| Last Name ( <i>Family Name</i> ) from Section 1. | First Name ( <i>Given Name</i> ) from Section 1. | Middle initial (if any) from Section 1. |
|--|--|---|

**Instructions:** This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

| Date of Rehire ( <i>if applicable</i> ) | New Name ( <i>if applicable</i> ) |                         |                |
|---|-----------------------------------|-------------------------|----------------|
| Date ( <i>mm/dd/yyyy</i> )              | Last Name (Family Name)           | First Name (Given Name) | Middle Initial |

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

|                |                          |  |
|----------------|--------------------------|--|
| Document Title | Document Number (if any) | Expiration Date (if any) ( <i>mm/dd/yyyy</i> ) |
|----------------|--------------------------|--|

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

|   |  |                                    |
|---|--|------------------------------------|
| Name of Employer or Authorized Representative | Signature of Employer or Authorized Representative | Today's Date ( <i>mm/dd/yyyy</i> ) |
|---|--|------------------------------------|

|  |   |
|--|---|
| Additional Information (Initial and date each notation.) | Check here if you used an alternative procedure authorized by DHS to examine documents. |
|--|---|

| Date of Rehire ( <i>if applicable</i> ) | New Name ( <i>if applicable</i> ) |                         |                |
|---|-----------------------------------|-------------------------|----------------|
| Date ( <i>mm/dd/yyyy</i> )              | Last Name (Family Name)           | First Name (Given Name) | Middle Initial |

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

|                |                          |  |
|----------------|--------------------------|--|
| Document Title | Document Number (if any) | Expiration Date (if any) ( <i>mm/dd/yyyy</i> ) |
|----------------|--------------------------|--|

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

|   |  |                                    |
|---|--|------------------------------------|
| Name of Employer or Authorized Representative | Signature of Employer or Authorized Representative | Today's Date ( <i>mm/dd/yyyy</i> ) |
|---|--|------------------------------------|

|  |   |
|--|---|
| Additional Information (Initial and date each notation.) | Check here if you used an alternative procedure authorized by DHS to examine documents. |
|--|---|

| Date of Rehire ( <i>if applicable</i> ) | New Name ( <i>if applicable</i> ) |                         |                |
|---|-----------------------------------|-------------------------|----------------|
| Date ( <i>mm/dd/yyyy</i> )              | Last Name (Family Name)           | First Name (Given Name) | Middle Initial |

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

|                |                          |  |
|----------------|--------------------------|--|
| Document Title | Document Number (if any) | Expiration Date (if any) ( <i>mm/dd/yyyy</i> ) |
|----------------|--------------------------|--|

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

|   |  |                                    |
|---|--|------------------------------------|
| Name of Employer or Authorized Representative | Signature of Employer or Authorized Representative | Today's Date ( <i>mm/dd/yyyy</i> ) |
|---|--|------------------------------------|

|  |   |
|--|---|
| Additional Information (Initial and date each notation.) | Check here if you used an alternative procedure authorized by DHS to examine documents. |
|--|---|

# Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

### Step 1: Enter Personal Information

|   |           |   |
|---|-----------|---|
| (a) First name and middle initial   | Last name | (b) Social security number  |
| Address   |           | Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> . |
| City or town, state, and ZIP code   |           |   |
| (c) <input type="checkbox"/> Single or Married filing separately  |           |   |
| <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse  |           |   |
| <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.) |           |   |

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

### Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

- (a) Reserved for future use.
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

**TIP:** If you have self-employment income, see page 2.

Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

### Step 3: Claim Dependent and Other Credits

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by \$2,000 \$ \_\_\_\_\_

Multiply the number of other dependents by \$500 . . . . . \$ \_\_\_\_\_

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . .

**3** \$

### Step 4 (optional): Other Adjustments

(a) **Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . .

**4(a)** \$

(b) **Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . .

**4(b)** \$

(c) **Extra withholding.** Enter any additional tax you want withheld each pay period . . . . .

**4(c)** \$

### Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

\_\_\_\_\_  
Employee's signature (This form is not valid unless you sign it.)

\_\_\_\_\_  
Date

### Employers Only

Employer's name and address

First date of  
employment

Employer identification  
number (EIN)

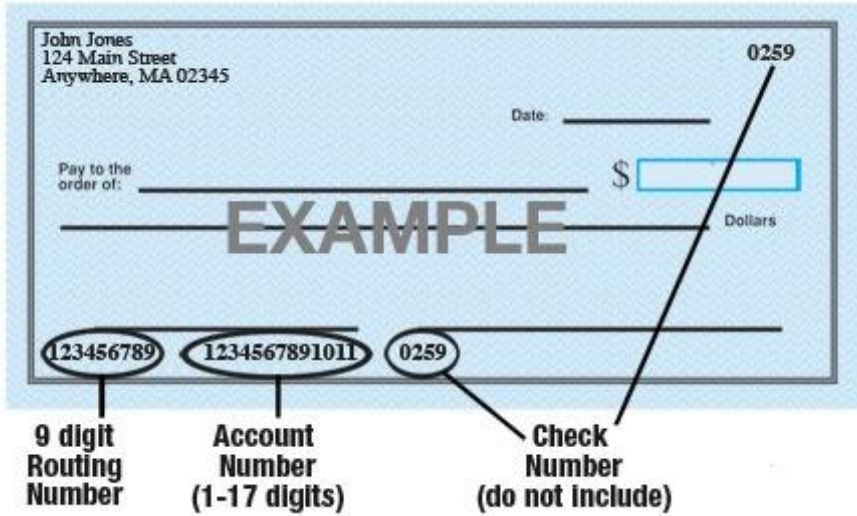
# Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_



Name of Bank: \_\_\_\_\_

Account #: \_\_\_\_\_

9-Digit Routing #: \_\_\_\_\_

Amount:  \$ \_\_\_\_\_  \_\_\_\_\_ % or  Entire Paycheck

Type of Account:    Checking    Savings    (Circle One)

*Please attach a voided check for each bank account to which funds should be deposited.*

Agency is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## ACH AUTHORIZATION AGREEMENT

|   |                 |             |      |
|---|-----------------|-------------|------|
| Company Name:   |                 | Company ID# |      |
| <p>I hereby authorize <b>Agency</b> to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any error to my (<i>select one</i>) checking or savings account at the depository financial institution named below.</p> <p>I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.</p> |                 |             |      |
| Depository Financial Institution Name:  |                 |             |      |
| Branch:   |                 |             |      |
| City:   |                 | State:      | Zip: |
| Routing #:  |                 |             |      |
| Account #:  |                 |             |      |
| <p><b>IMPORTANT:</b> Attach a VOIDED check for the above referenced account to this form.</p>   |                 |             |      |
| <p>This authorization is to remain in full force and effect until <b>the Agency</b> has received written notification from me of its termination in such time and in such manner as to afford the Payroll Specialist and DEPOSITORY a reasonable opportunity to act on it.</p>  |                 |             |      |
| Name:   |                 |             |      |
|   | (Please Print.) |             |      |
| Signature:  |                 |             |      |
| Date:   |                 |             |      |